



GLENN TISMAN, M.D.
A MEDICAL CORPORATION
HEMATOLOGY • ONCOLOGY
13025 BAILEY STREET, SUITE A
WHITTIER, CA 90601

Payment Responsibility Form

Dear Patient:

Glenn Tisman, M.D., A Medical Corporation is committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Any co-payments, deductibles, co-insurance, non-covered services or amounts in excess of your policy's lifetime maximum are due and payable at time of service. Professional services are charged to the patient. As a courtesy to you, we will complete necessary forms to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements are made in advance with our office bookkeeper.

_____ (initial)

Authorizations: Patients not confirming prior authorization procedures per their policy and/or requesting services when authorization has been denied or has not been obtained will be billed as a private pay account.

_____ (initial)

Referrals: In the course of providing care, doctor may refer you to facilities or other physicians that are out of your coverage network. Because all policies and networks are different, it is the responsibility of the patient to determine whether or not the referred physicians/facilities are within their coverage network and how that affects their personal financial responsibility.

_____ (initial)

Collection Measures: Accounts not resolved within sixty (60) days may be referred to an outside agency for further follow up.

_____ (initial)

My signature below acknowledges that I have received a copy of this form and understand my financial responsibility.

Patient Signature

Print Name

Date